



Request for Prior Authorization  
Vonoprazan (Voquezna)

FAX Completed Form To  
1 (877) 733-3195



(PLEASE PRINT – ACCURACY IS IMPORTANT)

Provider Help Desk  
1 (844) 236-1464

IA Medicaid Member ID # 	Patient name	DOB
Patient address		
Provider NPI 	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI 	Pharmacy fax	NDC 

Prior authorization (PA) is required for vonoprazan (Voquezna), Voquezna Dual Pak, and Voquezna Triple Pak. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of healing of erosive esophagitis (attach endoscopy results for initial diagnosis), maintenance of healed erosive esophagitis (attach endoscopy results for initial diagnosis), and relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD); and
  - a. Documentation of an 8-week trial and therapy failure, based on ongoing symptoms, with two preferred PPIs, each twice-daily dosing; or
3. Patient has active *Helicobacter pylori* (*H.pylori*) infection (attach documentation); and
  - a. Patient has documentation of a recent trial and therapy failure with a preferred agent(s) for the treatment of *H. pylori* infection; and
  - b. Request is for the triple pak or dual pak.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

If the criteria for coverage are met, requests will be evaluated for the dosage and duration of therapy according to the indications specified on the FDA approved label.

**Non-Preferred**

☐ Voquezna      ☐ Voquezna Dual Pak      ☐ Voquezna Triple Pak

Strength	Usage Instructions	Quantity	Day's Supply
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Diagnosis (attach documentation): \_\_\_\_\_

**Healing of erosive esophagitis, Maintenance of healed erosive esophagitis, Relief of heartburn associated with non-erosive GERD:**

**Preferred PPI Trial 1:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

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**Preferred PPI Trial 2:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

**Active *H. pylori* infection:**

**Trial of preferred agent:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*